PATIENT SAFETY

FEEDBACK

Patient Safety Reporting System
P.O. Box 4
Moffett Field, CA
94035-0004

Volume 1, Issue 2, Fall 2002

FEEDBACK shares excerpts of reports sent by VA employees to PSRS. Actual quotes appear in *italics*. Created by an agreement between NASA and the VA in May 2000, PSRS is a voluntary, confidential and non-punitive reporting system. PSRS encourages VA employees to describe safety issues from their own firsthand experience and to contribute their information to the PSRS.

Reports Highlight Safety

These three reports to PSRS describe safety issues that affect both patients and VA employees. In each case, measures taken to protect one would protect the other.

As the Tourniquet Turns

Natural rubber latex allergy affects about 10% of health care workers (Ann. Allergy Asthma Immunol., June 2002). A recent report notes 8.2% of emergency department admissions found to be seropositive (Ann. Emerg. Med., October 2002). Other research documents the dramatic increase in latex allergy in both populations over the last 15 years (J. Allergy Clin. Immunol., August 2002). A PSRS report focuses on this topic.

The reporter described what happened after a laboratory technician used a latex tourniquet on a patient who was admitted for anaphylaxis.

- *Patient had a suspected reaction and when lab was notified,* [they] *downplayed the event. They felt we should have notified them of the patient's allergy. The patient did not have a known latex allergy.*
- *Routinely using latex items on all patients without asking them about possible latex allergy is a safety concern.*

The reporter wrote that this is an exception to the progress being made in other departments.

- *Other units have converted to all non-latex products to ensure staff and patient safety. We have also initiated a latex allergy cart containing non-latex items.*

But those carts are issued by Central Supply only when a patient is known or suspected to be latex sensitive or allergic. The patient in question did not raise that initial suspicion.

A later conversation between the reporter and a PSRS analyst confirmed the steps being taken to avert future problems. Education regarding latex allergy prevention measures have begun for laboratory staff. Further improvement initiatives will entirely replace latex tourniquets as well as bandaids with non-latex items.

Mysterious Cleaning Solution

A reporter described the importance of properly labeling cleaning solutions for monitors, pumps and equipment carts:

- *When I arrived tonight, there was a spray bottle labeled Sunshine Liquid-Enzyme Odor Eliminator. On the bottle was a piece of surgical tape labeled "cleaner/disinfectant." I have no idea what product this actually is or what the biohazards for this product are. I also don't know if I actually have a disinfectant to disinfect the equipment. Last week we had a totally unlabeled bottle. I feel this is unsafe for both biohazard and cross contamination issues.*

Slip, Slide and Away

A reporter works on a locked psychiatric unit where shower curtains are not allowed due to suicide precautions. But that restriction has some unintended effects:

- *The shower stalls in the rooms are designed in a way that water goes all over the bathroom floor when a veteran takes a shower... Sometimes water goes into the room and hallway. The floor is very slippery and the veteran sometimes falls.*

The staff came up with their own method of "managing" the resultant flooding with its own unintended consequences.

- *The only way to stop the water from going on the floor is to put a folded blanket on the floor so the blanket soaks up the water. The blankets are very heavy from the water. The veteran can injure their back putting the wet blankets in the hamper. The employee can injure their back while taking the linen bag out of the hamper.*

The reporter noted that numerous falls have resulted, some with injuries. Administration is aware that wet floors have become a problem since the unit opened.

What a Difference a Decimal Makes

Reports to PSRS can take several different formats. A reporter can document a safety situation, write about immediate corrective measures, talk about contributing factors, or give suggestions for the future. This reporter did all four!

The safety situation began during surgery, when the patient's blood glucose level reached 309.

- *We decided to give 4 units of regular insulin. I obtained the regular insulin vial from the OR refrigerator (its usual location). It was the typical 10-ml vial of 100 units per ml. I took an insulin-marked 1 ml syringe. However, while I intended to draw up and give 4 units… I drew up 0.4 ml.*

That meant that 40 units of insulin was given intravenously instead of 4 units.

- *Within 1-2 minutes I realized the error and told the resident. Together we quickly decided to "back bleed" the IV, which flowed briskly backwards (fortunately). We took off about 20 ml and then forward flushed the IV tubing, about 30 ml.*

Surgery and recovery of the patient proceeded uneventfully.

- *I know that this type of error (near-miss or actual error) with insulin has been made before in several settings. Contributing factors in this case were: i) moderate workload; ii) teaching in progress; iii) relative unfamiliarity with insulin administration (we do it only rarely); iv) labeling of vial ...in small print.*

The reporter shared some thoughts about prevention:

- *Always double check insulin delivery with a second individual... Consider [asking] pharmacy to make up dilute vials of insulin labeled clearly with concentration and "FOR IV USE" and place these in the OR refrigerator since we virtually always use insulin IV in the OR and NOT subcutaneously. We would then eliminate the extremely concentrated insulin vial from the OR.*

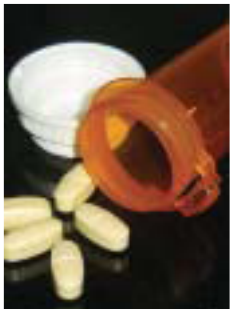
Cutting Pills Takes Skill

This reporter gets many similar telephone calls from outpatients:

- [Patients are] *having problems cutting medications in half to obtain the required dosage. I also have calls from vets who received 45 pills for 90 days medication coverage and the vet is out [of medication] because he took 1 tablet daily instead of one-half tablet daily as labeled.*

Not to mention the effect of receiving twice the ordered dose!

- *VA deals with a lot of vets who are elderly, have vision, dexterity, mental health, and other limitations that make cutting tablets difficult, even with a pill cutter.*
- *Problems with the tablets range from small in size, not scored for cutting, odd shapes. Many fracture into small pieces.*



The reporter adds that no one evaluates medications beforehand for "cutability." This problem could lead to calls for early refills due to double dosing or fracturing of pills thus not assisting the VA in cost-saving measures.

Coming Up for Air

A reporter attempted to give a breathing treatment to an Emergency Department patient, but could not do it.

- *"[] noted wall air did not work. Later found out that this was a planned outage for entire day and no alternatives were arranged and we were not even notified."*

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National Aeronautics and
Space Administration
MS IHS 262-7
Ames Research Center
Moffett Field, California 94035-1000